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Connecticut State Medical Society
Testimony In support
Senate Bill 370 An Act Concerning Health Care Provider lists and Authorizing Pregnancy As A Qualifying Event For Special Enrollment Periods
Presented to the Insurance and Real Estate Committee
March 10, 2016

Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee, on behalf of the physicians and physicians in training of the Connecticut State Medical Society (CSMS), thank you for the opportunity to present this testimony to you today in support of Senate Bill 370 An Act Concerning Health Care Provider lists and Authorizing Pregnancy As A Qualifying Event For Special Enrollment Periods. This bill will increase the transparency required by health care insurers regarding the networks they offer to enrollees and require certain specific information to be provided to enrollees regarding the network of providers in their plan.

Currently, network adequacy requirements contained in state statute simply require an insurer to be accredited by one of two entities: the National Commission on Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). However, this requirement is woefully inadequate and does not guarantee a network is adequate based on both geographic needs and the need for specialty or sub-specialty care. In addition, accreditation does not guarantee that 100% of adequacy requirements have been met. It is a pass/fail process.

The passage of the Accountable Care Act (ACA) has increased the number of citizens with health insurance coverage. It has also increased the number of plans and products under which one can receive coverage. However, at the same time, examples are increasing in which insurers are limiting, narrowing or tiering their provider networks. Particularly in plans offered through the Connecticut Exchange in which multiple variations of tiered and narrow networks exist. Each of these tiers or narrowed network should be required to demonstrate adequacy as a stand alone network and out of network access to care should not constitute network adequacy or any sufficiency of network. In many situations, it is difficult for enrollees to obtain accurate information regarding physicians available to them within a network. Conversely, physicians are having an increasing difficult time identifying the networks in which insurers consider them networked providers.

Given these changes to the health insurance market, coupled with the potential for further consolidation of the market, we do ask that the legislation before you today be expanded beyond the simple need to provide the required transparent information regarding the network, but also establish requirements for the network itself.

An important element of adequate health care coverage is that a health insurer offers an adequate network of contracted physicians and other health care providers, (e.g., the "provider network"). The provider network must be clearly identified. Critical to the network is that consumers can receive specialized and sub specialized care within the "in-network" environment. If a consumer has to obtain care in an "out of network" environment, there may be significant financial disincentives for that patient to receive care. Inadequate provider networks deprive consumers of the benefit of the money they have paid for health care coverage. Additionally, the entire public health and welfare system is undermined by forcing consumers to look out of network for services, consequently reducing utilization of appropriate preventive services and forgoing necessary medical care. Inadequate networks do not contain access to highly specialized care. As a result, this lack of necessary care has the effect of driving the sickest patients - those who need health insurance the most - out of that network, and therefore potentially benefitting the health insurance issuer's profit margin with fewer risky patients. To meet consumers' reasonable expectations and maximize their welfare, health insurance benefits, including all medically necessary and emergency care, must be available at the preferred, in-network rate on a timely and geographically accessible basis to all enrollees. Consumers and state insurance regulators need meaningful measures of network adequacy covering all aspects of the network, including emergency and other hospital-based physicians, taking into account any tiering or other network restrictions that may exist.

In addition to subjective satisfaction data, there is a need for objective data on critical access metrics, such as the number of visits to out-of-network providers per thousand enrollees, the percentage of services received from in-network providers as a percentage of total services received by enrollees, and the percentage of total costs for in-network and out-of-network services received by enrollees which were paid for by the health insurer. As health insurers' actuaries must evaluate the provider network to make premium determinations, these actuaries are positioned to provide reliable network reports to insurance regulators relatively efficiently.

The CSMS supports the need for transparency of provider networks to ensure insurance regulators and consumers have access to the information necessary to determine whether the provider network includes a sufficient number of primary care, specialty and subspecialty physicians and other health care providers. We further support and urge this committee to expand SB 370 to include provisions for an adequate network as detailed above in addition to the provision to make information regarding the provider network more readily available,

transparent and accurate for patients as well as physicians who rely on this information to make informed decisions about who and where care delivery might occur.

A key component of determining the adequacy of the provider network is the provider directory. This bill is a good start at legislation regarding the provider directory requirements, but we believe more specificity and detail is needed as to what must be contained in a provider directory. Specifically:

1. Health insurers must offer an online provider directory available to the public, including physicians, without restrictions or limitations.
2. The directory should be searchable electronically by, at a minimum, provider name, practice area, city, zip code, product, tier, and whether or not the provider is accepting new patients.
3. For insurers that offer tiered networks, the directory must easily identify which providers participate in what tiers for a given network.
4. The directory should clearly state whether a provider is accepting new patients.
5. The directory should include an email address and a telephone number for providers and members to report directory inaccuracies.
6. Health insurers must promptly investigate and, when necessary, correct any issues within 30 business days if they receive a report of a possible inaccuracy in the directory.
7. If a provider is listed as participating in error and an enrollee reasonably relied upon that information, the health insurer shall be required to pay for covered services to reimburse the enrollee for any amount beyond in-network cost sharing.
8. Health insurers must have a process to ensure accuracy in the directory and must at least annually conduct a thorough review and update of directory.

Provider directory transparency and network adequacy are critical elements of knowledge for a consumer today in light of the shifting of cost and risk tied to high deductible health plans with excessive out of network limits that put patients at great financial risk and harm.

We look forward to the opportunity to work with Committee members on the issue of network adequacy to ensure that the best possible language is passed by the General Assembly.